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UPGROWTH HEALTHCARE PLAYBOOK 06

International Patient Acquisition

How to build inbound medical travel demand one source country at a time, without your own distribution bidding against you.

HEALTHCARE

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Why this playbook exists

An international enquiry rarely looks like a lead. It arrives on WhatsApp at 11pm your time, from a son in Lagos or a cousin in Dubai, with a photograph of a discharge summary attached and 1 question under it: how much, and how soon. What follows is a travel decision as much as a clinical one, and most of it happens in weeks your hospital neither controls nor measures.

This category breaks the assumptions a domestic funnel is built on. The person deciding is not the person being treated. A large share of the flow arrives through facilitators paid a commission on the bill, so your own distribution and your own marketing chase the same patient with the same money. The path from first message to arrival runs through a mission, an airline and a bank, none of which will tell you what happened. And the buyer cannot visit, cannot ask a neighbour, and is preparing to move a large sum to an institution in a country they have never entered.

What follows is the operating structure: who is on the other end of the message, how to run an agent network and a direct channel without one eating the other, a funnel with 7 states rather than 3, the logistics answers that end more enquiries than clinical comparison does, an estimate a family can actually compare, and a planning table that replaces the single International Patients page almost every Indian hospital publishes.

Who this is for
Marketing and growth leads at Indian hospitals and clinic chains that already treat, or want to treat, patients travelling in from outside India, and the international desk that owns the half marketing cannot see. Nothing here is visa, immigration, tax or legal advice, and the sections touching those areas say where the answer has to come from instead. Regulatory references were checked against the bare text in August 2026. The specialty version sits on our medical tourism and international patient marketing page.

WHAT IS IN THIS PLAYBOOK

01 The enquiry is never from the patient

Almost every asset an Indian hospital publishes for international patients is addressed to the patient. Almost every enquiry is sent by somebody else. That is not a tone problem. It changes which questions the page answers, which hours the desk works and which language it is written in. You are answering an intermediary who carries risk on somebody else's behalf and will be blamed if it goes wrong.

The 5 senders, and what each is actually asking

Who sends the first message	The question underneath it	How you lose them
Adult child or sibling abroad	Can I trust these people with my parent when I am not in the room	A reply 2 days later, in your hours, with no name on it
Spouse or attendant who travels	What happens to me for the weeks we are there	No answer on where they sleep, eat or wait
Facilitator or agent	Will this hospital make me look good, and settle on time	Slow estimates, and a desk that treats them as a nuisance
Referring clinician abroad	Will my patient come back to me, with a report	Silence after discharge
Embassy, employer or insurer desk	Do you meet the panel terms, tariff and paperwork	No empanelment contact, no tariff, no documents

- **Publish a number that accepts WhatsApp, and answer on it.** A form promising a callback in 24 hours is a decline where 3 hospitals were messaged the same evening.
- **Set the response target in the sender's local time.** Lagos, Dubai, Dhaka and Tashkent are 4 different working days, and your 10am is somebody's shortlist closing.
- **Write to the sender, and name a human.** The page that converts addresses a working adult organising treatment for a parent, in the language they message you in, and it has a face on it.

> **The thing to do on Monday**
> Ask a contact in your largest source country to message your published international number at 9pm their time, with a discharge summary page with identifiers removed and 1 line of question. Log 3 things: how long until a human replied, whether the reply carried a name, and whether it answered the question rather than requesting a form.

The enquiry that begins as a second opinion

A large part of high-value cross-border demand does not begin as a request to travel. It begins as a request to have records read. Different service, different clock, and the most reliable entry into this funnel, because it is the only step a family can take without spending anything but time. Treat it as a product with an owner, a turnaround target and a report format. Mechanics in Pain in the Diagnosis.

02 The agent economy

Facilitators and agents carry a large share of the inbound flow reaching Indian hospitals, and they are paid a commission on the bill. That is the biggest structural fact in this category. No media plan resolves it and no attribution tool resolves it. It gets settled commercially, before the first campaign runs.

What sits behind the word agent

- **The individual facilitator** in the source country, often a former patient or a relative of one. Relationships and messaging groups, a handful of hospitals, a small steady flow.
- **The aggregator portal,** routing or selling the same enquiry to several hospitals at once. You pay to enter a race decided by whoever replies first.
- **The overseas clinic or diagnostic tie-up,** which behaves like a referring clinician, expects to be treated as one, and leaves quietly when the report stops coming back.
- **The arrival network** of drivers, guest houses, interpreters and currency agents who acquire patients after they land and can move them between institutions.
- **The desk you employ,** which is not an agent but is the channel competing with all of the above, usually staffed as though its flow were free.

> **You are bidding against your own distribution**
> A hospital running direct international campaigns while paying commission on agent-sourced arrivals is buying demand its own channel is already paid to deliver. Worse than duplication: an enquiry your marketing generated can be claimed by an agent after arrival, because somebody met the patient at the airport and nobody recorded who was first. You pay twice for 1 patient, and direct reports a cost per arrival that looks indefensible in the next budget meeting. The fix is a written first-contact rule agreed with the network before you spend anything, and an identifier captured at the desk by your own staff.

The first-contact rule

1. **The channel that made first contact owns the episode.** First contact is the first message, call or walk-in recorded against that patient, with a timestamp.
2. **Attribution is fixed there and cannot be claimed retrospectively.** A code presented at admission, when a direct enquiry already exists on record, changes nothing.
3. **Every active agent has a code and the desk asks for it.** Asked by registration staff from a controlled list, mandatory, with a no-agent option used as often as it is true.
4. **No code at first contact means direct, permanently.** If nobody can establish an agent, the record says direct and stays direct.
5. **Disputes go to 1 named person and the decision is logged.** Expect them in the first quarter, and expect them to stop once the network sees the rule applied identically every time, including when it goes against you.

Report the 2 channels apart, on the right basis

Commission scales with the bill, so the more valuable the case, the more it costs to acquire through an agent. Media is broadly fixed and does not care how large the case is. Those 2 lines cross, and where they cross is the only number here worth arguing about.

Channel	What it costs you	Report this	What blending hides
Direct	Media, coordinator time, translation	Cost per patient arrived, by source country	That the desk, not the campaign, is the constraint
Agent or facilitator	Commission, as a share of the bill	Net revenue per patient arrived, after commission	That margin falls as case value rises
Overseas clinician	Reporting, access, coordination	Patients per referring name per quarter	A referrer who has quietly stopped
Employer or insurer panel	Tariff concession, documents	Utilisation against the contracted volume	A renewal date nobody owns
Arrival network	Margin you never priced	Arrivals where a code was added after admission	Attribution rewritten at your own front desk

Illustrative arithmetic, figures invented to show the shape
Set commission at 15% of the bill. On a case billing 4 lakh that is 60,000. On a case billing 12 lakh it is 1.8 lakh, for the same agent work. If direct costs you 45,000 per patient arrived and stays roughly flat whatever the case value, direct is cheaper on every case above about 3 lakh and the gap widens from there. That is not an argument to stop paying commission. It is an argument that direct investment belongs where the bills are largest, settled per specialty rather than in general. Build it on your own figures with our patient acquisition cost calculator.

What the rule does not fix

The code itself is an operational object, not a marketing one. Issue it centrally, 1 per agent, printed on whatever the agent carries. Revoke it when they go inactive for 2 quarters and make the desk ask for it out loud rather than accept it written on a form. An agent code that anybody can quote is not an identifier, it is a discount.

The first-contact rule will cost you agents in the first quarter, and some of them will frame it as loyalty. Most of the leavers were relying on retrospective claiming. The ones who stay are generating demand, and for the first time you will be able to tell which is which.

You will not remove agents from this category, and a hospital that tries usually discovers how much of its flow was never really its own. What the rule gives you is narrower and worth more: the 2 channels stop bidding for the same patient with the same money, every arrival carries the channel that produced it, and each channel is priced on the basis that matches how it actually charges you.

03 A funnel with 7 states

A domestic funnel ends at consultation attended. An international funnel has to survive weeks of elapsed time, 2 governments, an airline and a bank, most of it outside your building. Enquiries in and patients arrived gives you 1 percentage that cannot say which of those failed.

State	The observable event	Who owns it	Time it adds
Enquiry received	A message with a country and a contact	Marketing	Nil
Estimate issued	A banded all-in estimate has been sent	International desk	Hours to days
Invitation letter issued	Your letter has left your desk	International desk	Days
Visa issued	The family or agent tells you	Nobody in-house	Weeks
Flight booked	You hold an arrival date	Family or agent	Days to weeks
Patient arrived	The patient is physically in your OPD	Operations	Nil
Treatment started	The first billable clinical event	Operations	Days

One precondition is missing on purpose. Before an estimate can be issued somebody qualified has to read what was sent, and that step usually has no clock, no owner and no queue. Timestamp it anyway: records received, records reviewed. The first-response failure that eats domestic enquiries eats these at a far higher value: Pain in the Handover.

A blended international conversion rate is a concealing metric
That number falls when a mission slows, when a currency moves, when a competing destination promotes, and when your desk takes a week to price a case. It looks identical in all 4. Report enquiry to visa issued and visa issued to arrived as 2 separate rates, and never publish the product of them.

The 2 gaps fail for unrelated reasons

Enquiry to visa issued is the half you can act on, and nearly all of it is yours: how fast records were read, how fast the estimate went out, whether it answered the question the family asked, how quickly the letter followed, whether anybody stayed in contact. When this rate is poor the cause is internal turnaround, fixable in a fortnight without spending anything.

Visa issued to arrived is the half you mostly cannot. A family that clears the hardest step and still does not travel has usually run into money, a change in the patient's condition, an attendant who could not come, or an agent who moved them during the wait. You cannot compress a mission's timeline. You can fix the silence: a cadence agreed before the wait starts, a named owner and a next-contact date on every waiting case, a logged reason whenever one stops moving. No feed tells you a visa has been granted, so that state exists only because somebody asked.

04 The travel decision

Ask an international desk why an enquiry died and you hear that the family went elsewhere. Ask the family and you hear about a document, a cost nobody mentioned, a place to stay, or nobody answering in a language they speak. Logistics end more of these enquiries than clinical comparison does.

The 7 questions that decide a travel case

1. **Documents and the invitation letter.** What you issue, what you need to issue it, how long your side takes.
2. **The attendant.** Almost nobody travels alone. Whether one can stay in the room, what that adds, what happens when 2 relatives come rather than 1.
3. **Length of stay.** Not days admitted. Total days in India, including days after discharge. That decides the budget and the leave.
4. **Accommodation.** What exists within walking distance, at what nightly range, and whether your desk can hold a booking.
5. **Food.** Unglamorous and decisive. What is in the hospital, what a family cooking for a patient can do, what is nearby.
6. **Language and interpretation.** Which languages you cover, at which hours, by named staff rather than an app, including what you do not.
7. **Money.** Currencies accepted, whether a card or transfer works, the deposit and when it falls due, refunds if the plan changes.

Do not give visa or immigration advice. Not 1 sentence.
This is the most searched part of the journey and the part a hospital must not answer. Do not name categories, eligibility criteria, permitted durations, document checklists, extension routes or registration after arrival. Those rules sit with the relevant mission and with the authorities of both countries, they change without notice, and a page that went stale causes real harm. Publish your process, point at the official source.

Publish your process, point at the official source

- **Describe only what your organisation does.** Your letter, your records review, your coordinator, your timelines, your fees.
- **Link out for everything else,** to the official government or mission source, labelled as the authority. Paraphrase is where the error enters.
- **Date the page, name an owner, and say plainly what you do not do.** One line stating you cannot advise on immigration removes a category of question your desk answers informally over WhatsApp.
- **Write it in the languages your enquiries arrive in.** This is the page families forward to each other and the page an agent screenshots. It is almost never the page a marketing team funds. Build it once, with names, prices and distances on it.

05 The estimate, and the site visit you cannot offer

A family in Nairobi or Tashkent compares India against 2 or 3 destinations on 1 number: the total cost to arrive, be treated, stay and go home. Almost nobody publishes it.

What an all-in estimate has to contain

- **A band, not a point,** for a defined procedure, in a currency the family thinks in as well as rupees, stating room category, days admitted and total days in India. Room category is the largest swing factor in most bills.
- **What is inside it.** Surgeon and anaesthetist fees, theatre, implants, ward stay, investigations, medication.
- **What is outside it, and what moves it.** Flights, accommodation, the attendant, food, interpretation. Anything found on arrival that was not in the records. Date it, and name who firms it up.

> **An estimate you cannot stand behind is worse than no estimate**
> The temptation is to publish the floor, because the floor wins the comparison. A family billed near the ceiling tells everybody in their community, and here the community is the channel. Publish a range wide enough to be honest and narrow enough to be useful, then audit it quarterly against your last 20 discharged cases and correct the band.

Trust when the buyer cannot visit

- **Accreditation stated plainly and checkable.** Name what you hold, the issuing body and the reference, and link to the register.
- **A named coordinator with a real photograph,** not a stock image and not a mailbox. A direct number that accepts WhatsApp, the languages they speak, a response time published in the sender's timezone.
- **The whole process written down in order,** from first message to going home, who does what and how long.
- **Clinician profiles that resolve,** and payment terms in writing: deposit, currency, what happens to money already paid. Most of all where the ticket is largest: oncology and cancer hospital marketing and orthopaedics and joint replacement.

Want the estimate built rather than described

We take 1 procedure you want to attract and build the banded all-in estimate from your own billing data. 30 minutes to scope, and the model stays with you.

Book a 30 minute growth call or write to contact@upgrowth.in

06 One plan per country, not 1 international page

Nigeria, the UAE, Bangladesh and Uzbekistan are 4 different businesses that happen to share a hospital. Specialty mix, who pays, price sensitivity, language, platform, agent density, entry route and advertising rules all change across that map, and the only thing the 4 reliably share is the destination. A single International Patients page is the standard mistake here, usually written in English for a reader who is not the buyer.

The axes to fill in, per source country

Axis	The question to answer for each source country	What it decides
Specialty mix	Which procedures, by volume and by value	The pages you build, the split
Who pays	Family, employer, insurer, embassy or panel	Marketing, or empanelment
Price position	Which destinations are you compared against	The band you publish
Language	Which language does the first message arrive in	Site and ad language, interpreters
Platform	Where the shortlist is built, and on which app	Channel mix and creative format
Agent density	What share of arrivals carried an agent code	Additive spend, or duplicative
Entry route	Which city do they land in, or is it overland	Which location owns this market
Money movement	How does a family here actually pay you	Deposit rule and currency shown
Stay pattern	How many attendants travel, and for how long	Accommodation, food, the estimate total
Advertising rules	What may a foreign hospital say, and target	Whether it can run at all

Fill it in from your own admissions data first, then your international desk, then 5 unhurried conversations with agents who work that market. **West Africa, including Nigeria:** long-haul, so trips are infrequent, long and expensive, an attendant almost always travels, enquiries arrive in English from an adult child abroad, and shortlists are built inside community groups you cannot see. **The Gulf, including the UAE:** short-haul and frequent, with 3 buyer types that have nothing in common commercially, self-paying residents, expatriate workers on modest incomes and sponsored patients on employer, insurer or embassy panels, and a comparison often against staying put. **Bangladesh:** high frequency, often overland rather than by air, weighted toward total cost including travel, Bangla-language enquiries, dense agent activity, and repeat travel that makes continuity worth more than a first-visit offer. **Central Asia and the CIS:** Russian is the working language of the enquiry across much of the group, messaging apps rather than search carry the contact, and the countries inside it differ enough that treating the CIS as 1 market repeats the mistake 1 level down.

The advertising rules that bind you are the ones where the ad is served

A campaign aimed at a source country is governed by that country's rules, not India's. Several health markets treat medical advertising as a licensed activity with prior approval attached, some restrict what a provider outside the country may say at all, and testimonial and price-claim rules differ market to market. Platform policy sits on top and moves without notice. A creative cleared for 1 source country cannot be assumed compliant in the next. Clear each market on its own current rules before launch and record who cleared it. What you publish from India still has to satisfy the Indian rules: Pain in the Prescription.

Where the records live is a governance question, not an IT one

These enquiries arrive as health data, usually as a photograph on a coordinator's personal phone. The Digital Personal Data Protection Act, 2023 applies under section 3(a) to processing of digital personal data within the territory of India where it is collected in digital form, and it does not carve out patients who live elsewhere. Section 17(1)(d) exempts processing of personal data of Data Principals not within the territory of India done pursuant to a contract entered into with a person outside India by a person based in India, but whether a hospital's own treatment relationship sits inside that clause is arguable, and it is not a reading to build an operating model on. Commencement is by notification and the Rules were notified in November 2025 with obligations phased, so check the current notification. The operational answer does not wait for the legal one: records off personal phones, into a controlled system with named access.

Where to start

1. Rank source countries by revenue over 24 months, not by enquiry count. The list is usually shorter than assumed and 2 countries carry it. Take the top 2 and let everything below wait.
2. Fill in the axes for those 2 from your own data and your own desk, and mark which answers you are guessing at.
3. Build 1 estate per country: a landing page in the right language, banded estimates for the 3 procedures those patients come for, a logistics page with names and prices, and a named coordinator with a photograph and a direct number.
4. Circulate the first-contact rule, issue agent codes and make the field mandatory at registration before any of it goes live.
5. Report the 7 states weekly with the 2 gaps shown apart, by source country and channel, and retire the blended number in the same meeting.

Start with 1 country

upGrowth works with hospitals, clinics, diagnostics businesses and clinician groups on patient acquisition, search visibility and AI search presence. If you cannot say today what your largest source country costs you per patient arrived, that is the first hour of work.

Book a 30 minute growth call or write to contact@upgrowth.in

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DIAGNOSIS BEFORE PRESCRIPTION

Start with one number, not one campaign.

Most hospitals report 1 international conversion rate.
Split it at visa issued and the leak gets an address.
We will rebuild that funnel with you in 30 minutes.

Book a 30 minute growth call

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